MDR Tracking Number: M5-04-3039-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on May 14, 2004.

Per Rule 133.308(e)(1) date of service 05/12/03 was not filed within the 1-year time frame and will not be reviewed.

The IRO reviewed CPT Codes 97110, 97110-GP, 99212, 99213-MP, 99214, 97265, 97250, 97035, 97140, 97140-59GP, 98940, G0283 and 97010 for dates of service 05/14/03 through 08/04/03 that were denied based upon "V".

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

CPT Codes 97110, 99213-MP, 97265, 97250 and 97035 for dates of service 05/16/03 and CPT Codes 99214, 97110-GP, 97140-59GP. 98940, 97035, and G0283 for dates of service 07/29/04 through 08/12/03 **were** found to be medically necessary. CPT codes 97110, 99213-MP, 97265, and 99212 for dates of service 06/17/03 through 07/14/03 **were not** found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the medical necessity issues.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved.

On July 2, 2004, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

- CPT Code 99080-73 for date of service 07/14/03 denied as "V – Unnecessary medical with a peer review". Per Rule 129.5 Work Status Report the TWCC-73 is a required report and is not subject to an IRO review. The Medical Review Division has jurisdiction in this matter; therefore, per Rule 133.106(f)(1) reimbursement in the amount of $15.00 is recommended.

- CPT Code 98940 for dates of service 08/28/03 denied as "G". Per Rule 133.304 (c) and 134.202(a)(4) the carrier did not specify which code the denied code was global to; therefore, reimbursement in the amount of $30.14 ($24.11 x 125%)is recommended.

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the Respondent to pay the unpaid medical fees outlined above as follows:

- In accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) for dates of service through July 31, 2003;

- In accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202 (c);

- Plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order.

This Order is applicable to dates of service 05/16/03, 07/14/03 through 08/12/03 and 08/28/03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Decision and Order is hereby issued this 29th day of October, 2004

Marguerite Foster
Medical Dispute Resolution Officer
Medical Review Division

MF/mf
Enclosure: IRO decision

MEDICAL REVIEW OF TEXAS

[IRO #5259]

3402 Vanshire Drive Austin, Texas 78738
Phone: 512-402-1400 FAX: 512-402-1012

NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	
MDR Tracking Number:	M5-04-3039-01
Name of Patient:	
Name of URA/Payer:	Neuromuscular Institute of Texas
Name of Provider: (ER, Hospital, or Other Facility)	Neuromuscular Institute of Texas
Name of Physician: (Treating or Requesting)	Scott Walker, DC

July 30, 2004

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

Michael S. Lifshen, MD
Medical Director

cc: Rosalinda Lopez, Texas Workers Compensation Commission

CLINICAL HISTORY
Patient is a 41-year-old female Southwestern Bell employee who, on ___, sustained a repetitive trauma injury to both her left and right shoulders. After a trial of conservative chiropractic care and physical therapy, she eventually underwent arthroscopic surgery of her right shoulder on 03/31/03, and left shoulder arthroscopy on 07/18/03. Both procedures were followed by post-operative physical therapy and rehabilitation.

REQUESTED SERVICE(S)
Therapeutic exercises (97110 and 97110-GP), office visits (99212, 99213-MP and 99214), joint mobilization (97265), myofascial release (97250), ultrasound (97035), manual therapy techniques (97140 and 97140-59-GP), chiropractic manipulations (98940), electrical stimulation, unattended (G0283), and hot/cold pack therapy (97010) for dates of service 05/16/03 through 08/12/03.

DECISION
All treatment rendered on date of service 5/16/03, as well as the treatment rendered from 7/29/03 through 8/28/03 are approved.

All other procedures and services within the date range are denied.

RATIONALE/BASIS FOR DECISION
Physical medicine is an accepted part of a rehabilitation program following surgery. However, for medical necessity to be established, there must be an expectation of recovery or improvement within a reasonable and generally predictable time period. In addition, the frequency, type and duration of services must be reasonable and consistent with the standards of the health care community. General expectations include: (A) Patients should be formally assessed and re-assessed periodically to see if the patient is moving in a positive direction in order for the treatment to continue. (B) Supporting documentation for additional treatment must be furnished when exceptional factors or extenuating circumstances are present. (C) Evidence of objective functional improvement is essential to establish reasonableness and medical necessity of treatment.

After the patient's right shoulder surgery on 03/31/03, up to 18 post-operative rehabilitation treatments would be considered medically necessary, and this is even supported by the carrier's peer review performed on 07/18/03. Therefore, the care rendered on 05/16/03 was approved since it represented the 18th treatment following the surgery. However, the treatments and procedures from 06/17/03 through 07/14/03, exceed this expectation, and no medical records were provided to otherwise support their medical necessity. Therefore, the performance of these services cannot be supported.

After the left shoulder surgery on 07/18/03, up to 18 post-operative rehabilitation treatments would again be considered medically with the same rationale. Accordingly, all treatments and procedures performed from 07/29/03 through 08/28/03 were approved.